uSmile

PATIENT REGISTRATION

PATIENT # _____

PATIENT'S NAME _____ TODAY'S DATE ___/___/___
Last Name – (Please print) First Name Middle Initial

PATIENT'S ADDRESS _____ EMAIL _____

_____ PATIENT'S HOME PHONE _____ PATIENT'S WORK PHONE _____
City State Zip

FAX NUMBER _____ MOBILE NUMBER _____

PATIENT'S MARITAL STATUS ☐ Single ☐ Married (Spouse's Name) _____ PATIENT'S SCHOOL _____

PATIENT'S BIRTHDATE ___/___/___ AGE _____ SEX ☐ Male ☐ Female PATIENT'S SOCIAL SECURITY # _____

HOW DID YOU HEAR ABOUT US? _____

PLEASE LIST MEMBERS OF YOUR FAMILY WHO ARE PATIENTS OF OURS

_____ _____
Name Relationship to Patient Name Relationship to Patient

_____ _____
Name Relationship to Patient Name Relationship to Patient

A Local Friend or Relative
Not Living at our Address _____ RELATIONSHIP TO PATIENT _____

_____ PHONE _____
City State

PATIENT'S EMPLOYER _____ PATIENT'S OCCUPATION _____

EMPLOYER'S ADDRESS _____
Address City State Zip

PATIENT'S RELATIONSHIP TO PERSON RESPONSIBLE FOR BILL ☐ Self ☐ Spouse ☐ Child ☐ Dependent

PERSON RESPONSIBLE FOR THE BILL

NAME _____ RELATIONSHIP TO PATIENT _____
Last Name – (Please print) First Name Middle Initial

MARITAL STATUS ☐ Single ☐ Married SEX ☐ Male ☐ Female

MAILING ADDRESS _____ HOME PHONE _____

_____ WORK PHONE _____
City State Zip

SOCIAL SECURITY # _____

BIRTHDATE ___/___/___ EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____
Address City State Zip

ASSIGNMENT AND RELEASE: I certify that I am over the age of 18 years; or that I am signing on behalf of a patient who is a minor and I am fully responsible for all charges and terms. If I have dental insurance, I understand that any deductibles and the ESTIMATED portion of treatment fees not covered by insurance are due at time of treatment. uSmile does NOT guarantee insurance payments. I agree to make payment of all attorney's fees, costs and interest incurred if collection of my account is required. To maintain eligibility for regular or emergency dental treatment, I will follow the terms of any financial arrangement. Overdue accounts will be charged 18% interest per year. I hereby authorize my insurance benefits be paid directly to the doctor. I authorize the doctor or insurance company to release any information required for claims. All fees quoted for treatment are valid for 30 days. Missed appointments and NSF checks will be assessed a charge. I consent that to keep my health care information private, uSmile will not disclose any information to outside sources without my permission, this includes, but is not limited to, treatments not covered by my insurance policy. To keep my health care information private, I consent that information regarding treatments not covered by insurance will not be sent out of this office.

PATIENTS, PLEASE SIGN HERE: X _____

PERSON RESPONSIBLE FOR THE BILL (IF NOT PATIENT): X _____

INSURANCE INFORMATION

INSURANCE _____ INSURANCE _____

EFF. DATE _____ PHONE _____ EFF. DATE _____ PHONE _____

INSURANCE ADDRESS _____ INSURANCE ADDRESS _____

_____ _____
City State Zip City State Zip

SUBSCRIBER'S NAME _____ SUBSCRIBER'S NAME _____

___/___/___ _____ ___/___/___ _____
Subscriber's Birthdate Subscriber's Social Security Number Subscriber's Birthdate Subscriber's Social Security Number

_____ _____ _____ _____
Group # I.D.# Group # I.D.#

PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Child ☐ Dependent PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Child ☐ Dependent

SUBSCRIBER'S EMPLOYER _____ SUBSCRIBER'S EMPLOYER _____

EMPLOYER'S ADDRESS _____ EMPLOYER'S ADDRESS _____

Thank you for taking the time to fill out our registration form, please see the reverse side for some important information — we appreciate it very much!

071915

IMPORTANT INFORMATION FOR OUR PATIENTS

- As a courtesy, our staff will assist you in obtaining maximum dental insurance benefits. Your estimated dental insurance co-payments and deductibles are due at the time of service. We accept **VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND MOST DEBIT CARDS.**

- We now offer ***EASY PAY.*** This allows you to pay up to $500.00 over a period of 3 months with your debit or credit card. Please ask us for details.

- It is the patient's responsibility to carefully read his/her benefits booklet. This is very important, as your insurance company may have waiting periods or clauses that we are unaware of.

- Most insurance companies have a benefit maximum. This means the maximum dollar amount the insurance company will pay per benefit year. The average maximum an insurance company will pay per covered person is $1,000.00 to $2,000.00 per benefit year. This includes regular cleanings, exams and x-rays. It is a good idea for you to keep track of benefits you are using, especially if you are having extensive dental work.

- Most insurance companies pay on a percentage basis. For example, cleanings, exams and x-rays on average are paid at 100%, fillings, root canals and periodontics at 80%, and bridges dentures and crowns at 50%. Again, this is only an example of an average dental plan. Dental plans can vary greatly, so please read your insurance booklet carefully.

- Some insurance companies pay on a flat fee schedule, rather than a percentage basis. If your insurance company pays on a flat fee schedule, please obtain a copy of the fee schedule for our office to keep in your file. This will enable us to assist you in estimating your out-of-pocket costs.

- If the dentist recommends scaling and root planing, also known as a deep cleaning, **please be advised the average insurance company <u>does not</u> cover this at 100%, but generally 80%, and sometimes 50%. It is <u>very important</u> to talk with the Financial Coordinator about your co-payments prior to this procedure.**

- Our estimates are based on information provided by you and your dental insurance company. We do not guarantee benefits. If insurance payment is not received in a timely manner, the entire balance is due from you. You may then obtain reimbursement directly from your insurance company.

- Insurance companies do not cover missed appointment fees. Notification of cancellations must be received 48 hours prior to your appointment to avoid a missed appointment fee. Missed appointment fees are calculated on a hourly basis. Therefore, if you are scheduled for a lengthy appointment it is best to make sure it is convenient with your schedule to avoid costly missed appointment fees.

- Please call our Financial Coordinator at least 24 hours prior to each dental visit to go over your out-of-pocket expense that is due at the time of your appointment. Our Financial Coordinator is available Monday through Friday until 4:30 pm and can also provide additional assistance with your insurance benefits, account questions, or an easy payment plan.

I have read and understand the above patient information.

Signature: _____ Date: _____